EXHIBIT 1

Guardian®

X **Berkshire Life Insurance Company of America**
Home Office: 700 South Street, Pittsfield, MA 01201
A wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE: PART I

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name: Wairimu | Middle Initial: | Last Name: Waiyaki | Suffix:

Previous Last Name (if applicable): Waiyaki

B. Gender: [ ] Male [X] Female

C. Social Security Number: [redacted]

D. 1. Residence Address:

Street: 302 perimeter center north

City: Atlanta | State: GA | Zip Code: 30346-____

2. If less than two years, state prior address:

Street: 339 Meadow farm lane

City: Lawrenceville | State: GA | Zip Code: 30045-____

E. Date of Birth (mm/dd/yyyy): [redacted]1981

F. State, Country of Birth: Kenya

G. Phone: (678)469-1124

H. Email Address: wairimu.waiyaki@gmail.com

SECTION 1: PROPOSED INSURED INFORMATION (CONTINUED)

I. 1. Are you a U.S. citizen or green card holder? [X] Yes [ ] No

If No, please answer the following:

2. Visa Type:

3. Visa Duration:

4. Do you plan to reside in another country besides the U.S. in the next 2 years? [ ] Yes [ ] No

If Yes, include details:

5. When do you expect to obtain U.S. citizenship or permanent residency (green card)?

SECTION 2: BUSINESS INFORMATION

A. 1. Current Employer: Voya Financial

2. Number of years with current employer: > 2 years

3. If less than two years, state prior employer:

B. Business Address:

Street: 5780 Powers Ferry Rd

City: Atlanta | State: GA | Zip Code: 303274347

C. Business Website: www.voya.com

D. Nature of Business or Industry: Financial services

E. How many people are employed by your business/organization? 4000

F. 1. Is this a home-based business? [ ] Yes [X] No

2. If yes, what percentage of time do you spend working outside the home? %

SECTION 3: OCCUPATIONAL INFORMATION

A. Occupation: Computer Analyst

B. Number of years working in this occupation: 2

C. How many hours per week are you at work in this occupation? 40

D. 1. Job Title: Hr. Analyst

For Medical Occupations Only: Physicians, Fellows, Residents, and Students - Please list certification(s) or intended certification(s):

2. Medical Board Specialty Certification:

3. Medical Board Subspecialty Certification:

E. Academic degrees, professional licenses, and/or designations held (if none, so state):

BA in communication, MSC organizational development

F. 1. Are you any of the following?

☐ Student ☐ Resident ☐ Fellow ☒ None

2. If yes, what is your expected graduation date?

G. Describe the specific duties of your occupation, including but not limited to surgery, travel, sales, and supervisory duties. If the space provided is not adequate, provide additional details in Remarks & Special Requests Section 9.

Description of Specific Duties	% of Time Devoted to Each Duty
Data analysis	100%

H. 1. Do you ever perform any manual duties such as operating machinery, carrying or lifting objects in excess of 30 lbs., climbing ladders, or driving a delivery vehicle? ..... ☐ Yes ☒ No

If yes, please provide details:

2. Do you ever wear any protective gear or attire? ..... ☐ Yes ☒ No

If yes, please provide details:

SECTION 3: OCCUPATIONAL INFORMATION (CONTINUED)

I. Are you presently employed, and have you been continuously at work full-time (at least 30 hours per week) performing the usual duties of your occupation for the past 180 days? ..... [X] Yes [ ] No

If no, explain in Remarks & Special Requests Section 9.

J. Do you supervise any employees? ..... [ ] Yes [X] No

If yes, how many? [ ]

K. Employment Status? [X] Employee (no ownership)

[ ] Sole Proprietor or 1099 Employee

[ ] Partner [ ] % of ownership

[ ] S-Corp Shareholder [ ] % of ownership

[ ] C-Corp Shareholder [ ] % of ownership

L. Do you plan to change your occupation, occupational duties, job, or employment within the next six months? ..... [ ] Yes [X] No

If yes, provide details:

M. Do you have any other part-time or full-time occupations, jobs, or employment? ..... [ ] Yes [X] No

If yes, provide details:

SECTION 4: OTHER INSURANCE COVERAGE

A. Within the past five years, have you had any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused?..... ☐ Yes ☒ No

If yes, provide details in Remarks & Special Requests Section 9

B. 1. Within the past six months, have you applied for life insurance through The Guardian Life Insurance Company of America ("Guardian") or any other company?..... ☐ Yes ☒ No

2. If yes, what company? _____

C. Do you have any disability insurance in force or applied for, or for which you are eligible within the next 12 months with any company, including Guardian or Berkshire Life Insurance Company of America ("Berkshire")?.... ☐ Yes ☒ No

If yes, list all coverages in the chart below.

Type: Individual (IDI); Long-Term Disability (LTD); Short-Term Disability (STD); Overhead Expense (OE); Disability Buy-Out (DBO); Retirement Protection (RP); if other, please specify.

Include all sources of insurance including Association, Employer, Group, Self-Purchased, etc.

		Column A	Column B	Column C	Column D
1.	Company Name				
2.	Type				
3.	Status (In-Force, Applied For, Eligible For)				
4.	Benefit Amount				
5.	Benefit Period				
6.	Catastrophic Benefit				
7.	Retirement Protection				
8.	Employer-Paid*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	Is this coverage being replaced? If yes, date to be replaced	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____
10.	Amount to be replaced				

* *"Employer-paid" means your employer pays the premium and does not include it as taxable income to you.*

SECTION 5: PERSONAL FINANCIAL INFORMATION

For purposes of this section only, Earned Income means the income you are required to report to the Internal Revenue Service ("IRS") for income tax purposes. This includes W-2 wages, salary, bonuses, your share of net business income, and all other compensation you received for work or services. Explain in Remarks & Special Requests Section 9, any significant fluctuations between years.

A. Earned Income

1. Year-to-Date This Calendar Year: $45,000.00

2. Actually Filed with the IRS Last Calendar Year: $64,903.00

3. Actually Filed with the IRS Two Calendar Years Ago: $38,219.00

B. What percentage of your Earned Income is commission-based? 0 % (if none, enter 0)

C. Would you like to have contributions such as your 401(k) or 403(b) considered as part of your Earned Income?

☐ Yes ☒ No ☐ Not Applicable

If yes, complete question (D).

D. Total Annual Retirement Contributions:

Personal Contributions		**Employer Contributions**	
1. Year-To-Date This Calendar Year:		**4.** Year-To-Date This Calendar Year:	
2. Last Calendar Year:		**5.** Last Calendar Year:	
3. Two Calendar Years Ago:		**6.** Two Calendar Years Ago:	

SECTION 6: ADDITIONAL INFORMATION

(Please provide details in Remarks & Special Requests Section 9 to all "Yes" answers)

A. Have you or a business you've owned ever filed, or plan to file, for bankruptcy? ☐ Yes ☒ No

If yes, Type: ☐ Personal ☐ Business Filing Date: Discharge Date:

B. Within the next 2 years, do you plan to reside or travel outside of the U.S.? ☒ Yes ☐ No

C. Within the past 5 years, have you ever: pled guilty to, pled no contest to, or been convicted of reckless driving, driving while impaired or intoxicated, or any other moving violation; had your license suspended or revoked; or been involved in any accident in which you were found to be at fault? ☐ Yes ☒ No

D. In the past 10 years, have you ever pled guilty to, pled no contest to, or been convicted of any felony or misdemeanor? ☐ Yes ☒ No

E. Do any of the following apply? 1) Your professional or occupational license or certification has ever been suspended, revoked, restricted, inactivated, surrendered, or the like; 2) There is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) You have ever been disbarred; or 4) You have ever been fined or sanctioned by an entity that oversees your profession. ☐ Yes ☒ No

F. Have you participated within the last 3 years, or do you intend within the next 2 years to engage in any of the following activities: contact martial arts; mountain or rock climbing; motor sports events or racing (auto, truck, cycle, boat, etc.); scuba diving; skydiving; hang gliding; parachuting; and/or paragliding? ☐ Yes ☒ No

(If yes, complete the Avocation Supplement.)

SECTION 6: ADDITIONAL INFORMATION (CONTINUED)

(Please provide details in Remarks & Special Requests Section 9 to all "Yes" answers)

G. Have you used any tobacco or nicotine products and/or nicotine delivery systems in the last 12 months? ..... ☐ Yes ☒ No

(If you no longer use any of the above, date last used: ☐)

H. Are you currently a member of the US armed forces or National Guard, have you received military orders to appear for service, been placed on alert, or have you entered into a written agreement to become a member of the military?..... ☐ Yes ☒ No

SECTION 7: PREMIUM INFORMATION

A. What percentage of the premium for the coverage you are applying for will be paid by your employer?

☒ None ☐ 100% ☐ Other ☐

B. If your employer will pay any part of the premium, will it be reportable by you as taxable income? ..... ☐ Yes ☐ No

C. If any part of the premium is paid by you, is it paid with: ☐ Pre-Tax dollars ☒ After-Tax dollars

D. Premium Mode: ☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Monthly (available with Group Bill and Automatic Bank Draft only)

E. Billing Type: ☐ Paper Bill

☒ Automatic Bank Draft: ☒ New Service (Complete Request for Guard-O-Matic (GOM) Arrangement Form R223)

☐ Add to my existing Guardian or Berkshire services – GOM #: ☐

☐ Group Bill: ☐ Existing Group # ☐

☐ New – Billing Name: ☐ Common Billing Day ☐

F. Send premium notices to:

☒ Residence

☐ Owner's Address

☐ Business

☐ Other

☐

G. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditional Receipt.*

☒ No money has been submitted with this application.

☐ ☐ has been submitted with this application.

See Supplement for Application for Insurance

SECTION 8: COVERAGE APPLIED FOR

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate application supplement as noted below:

- [X] Individual Disability (Including Retirement Protection) – Complete Individual Disability Insurance Supplement
- [ ] Overhead Expense (Including Business Loan Protection) – Complete Overhead Expense Insurance Supplement
- [ ] Disability Buy-Out – Complete Disability Buy-Out Insurance Supplement
- [ ] Reducing Term – Complete Reducing Term Insurance Supplement

SECTION 9: REMARKS & SPECIAL REQUESTS

Identify each detail by question number. For additional space use the Supplement to Application for Insurance.

See Supplement for Application for Insurance

SECTION 10: AMENDMENTS OR CORRECTIONS (FOR HOME OFFICE USE ONLY)

SECTION 11: REPRESENTATIONS OF THE PROPOSED INSURED AND OWNER

Those parties who sign below, agree that:

1. This Application for Disability Insurance: Part I, Application for Insurance: Part II – Health and Medical History, any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Disability Insurance: Part 1 will form the basis for, and become part of and attached to any policy or coverage issued and is herein referred to as the "Application."
2. The Proposed Insured has read the application and all statements and answers as they pertain to the Proposed Insured, and all of the statements that are part of this Application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment, or may lead to rescission of any policy that is issued based on this Application.
5. All coverage you have identified to be replaced in answer to Question 4C of this Application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights provided in any policy issued and those available by law. Further, benefits under any policy or coverage issued based on this Application may be reduced by any monthly indemnity or benefit under such existing policies.
6. The policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued), no insurance shall take effect unless and until the policy is delivered, the first premium is paid, and there has been no change in the health, the income level, status of employment or occupation of the proposed insured. If disability insurance becomes effective in the manner stated in the Conditional Receipt, the amount of such insurance shall not exceed the limits set forth in such Receipt. If a request is made for coverage to commence as of a specified date, it is understood and agreed that certain rights under the conditional receipt may be waived.
7. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the owner upon acceptance of a policy containing this Application with the noted changes or corrections. Any change in plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the Proposed Insured.
8. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require written assurance within one year of the policy date that a written buy-sell agreement is in place. If no written assurance is received, the policy will be voided and the premiums refunded.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at City, State: Atlanta GA

Today's Date (mm/dd/yyyy): 8/3/2021

Signature of Proposed Insured: eSigned by Wairimu Waiyaki

Signature of Applicant/Owner if Other than Proposed Insured:

Witness Signature:

Guardian®

Customer Service Office
Mailing Address
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Supplement to Application for Insurance

The insurer identified below will be herein referred to as the "Company."

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Unless subsidiary checked below:

☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

☒ BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

This Supplement is to be attached to and made part of the policy.

Please print. *The Owner and/or Proposed Insured must initial any changes.*

SECTION A: Proposed Insured Information

First Name Wairimu MI _____ Last Name Waiyaki

Date of Birth (mm/dd/yyyy) [redacted]1981

Use space below to amplify and extend answers to questions in your application dated 8/3/2021.

Form #	Question #	Details
		Part 1 Section 5 - Personal Financial Information 5 - Significant fluctuations details: Worked half a year two years ago Part 1 Section 6 - Additional Information 6B - Travel details: Nairobi, Kenya December 15th 2021 to January 13th 2022. Visiting Family Part 1 Section 7 - Premium Information 7E - Billing Type: I have selected Monthly-Automatic Bank Draft Service and would like to provide banking information at policy delivery.

SECTION B: Signatures

I (We) represent that the answers as amplified and extended above are true and complete to the best of my (our) knowledge and belief and are part of my (our) application to the Company as described above.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at Atlanta GA 8/3/2021

City and State Month/Day/Year

eSigned by Wairimu Waiyaki

Signature of Proposed Insured

Signature of Applicant/Owner

Witness

IMNB00180002001O1

AppFile10

Guardian®

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
A wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE – INDIVIDUAL DISABILITY INSURANCE SUPPLEMENT

If applying for an individual disability insurance policy, complete sections 1 and 2 only. If applying for a separate Retirement Protection Plus policy, complete sections 1 and 3 only.

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name: Wairimu | Middle Initial: | Last Name: Waiyaki | Suffix:

B. Date of Birth (mm/dd/yyyy): [redacted]981 **C.** Occupation Class (if unsure, leave blank): 6

D. Is this part of an Approved Employee Multi-Life Program (Unisex Rates)? ☐ Yes ☒ No

E. GSI Case # (Fully Underwritten Buy-Ups Only):

SECTION 2: INDIVIDUAL DISABILITY INSURANCE

A. Monthly Benefit Amount: $4,000

B. Elimination Period:

☐ 30 Days ☐ 60 Days ☒ 90 Days ☐ 180 Days ☐ 360 Days ☐ 720 Days

C. Benefits Selection:
Select options from a single column only.

	Essential Package	Select Package	Premier Package
1. Definition of Disability	Two-Year Modified Own Occupation (Any Occupation Thereafter)	Two-Year True Own Occupation (Modified Thereafter)	True Own Occupation
2. Premium Structure	Level	☐ Level ☐ Graded	☒ Level ☐ Graded
3. Benefit Period	☐ 2 Year ☐ 10 Year ☐ 5 Year ☐ To Age 65	☐ 2 Year ☐ To Age 65 ☐ 5 Year ☐ To Age 67 ☐ 10 Year ☐ To Age 70	☐ 2 Year ☐ To Age 65 ☐ 5 Year ☐ To Age 67 ☒ 10 Year ☐ To Age 70

SECTION 2: INDIVIDUAL DISABILITY INSURANCE (CONTINUED)

	Essential Package	Select Package	Premier Package
4. Increase Option	N/A	☐ Future Increase Option ☐ Benefit Purchase Rider	☐ Future Increase Option ☐ Benefit Purchase Rider
5. Automatic Benefit Enhancement (ABE)	N/A	☐ Automatic Benefit Enhancement (ABE)	☐ Automatic Benefit Enhancement (ABE)
6. Mental and/or Substance-Related Disorders Limitation	12 Month	☐ 12 Month ☐ 24 Month ☐ Unlimited	☐ 12 Month ☐ 24 Month ☒ Unlimited
7. Partial/Residual Disability	☐ Short-Term Residual	☐ Enhanced Partial ☐ Basic Partial	☐ Enhanced Partial ☐ Basic Partial
8. Cost of Living Adjustment (COLA)	N/A	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum
9. Severe Disability *Cannot be combined with Catastrophic Disability*	N/A	☐ Severe Disability Benefit Amount	☐ Severe Disability Benefit Amount
10. Catastrophic Disability (CAT) *Cannot be combined with Severe Disability*	N/A	☐ Enhanced CAT Benefit Amount	☐ Enhanced CAT Benefit Amount
11. Extended Benefits	N/A	☐ Graded Lifetime Benefit for Total Disability ☐ Lump Sum Disability	☐ Graded Lifetime Benefit for Total Disability ☐ Lump Sum Disability
12. Retirement Protection	N/A	☐ Retirement Protection Plus Monthly Benefit Elimination Period: ☐ 180 Days ☐ 360 Days	☐ Retirement Protection Plus Monthly Benefit Elimination Period: ☐ 180 Days ☐ 360 Days
13. Student Loan Protection	N/A	☐ Student Loan Protection Rider (Complete Student Loan Protection Rider Supplement)	☐ Student Loan Protection Rider (Complete Student Loan Protection Rider Supplement)

SECTION 2: INDIVIDUAL DISABILITY INSURANCE (CONTINUED)

	Essential Package	Select Package	Premier Package
14. Additional Benefits	☐ Social Insurance Substitute Benefit Amount	☐ Social Insurance Substitute Benefit Amount ☐ Supplemental Benefit Term Rider Benefit Amount Elimination Period: ☐ 90 Days ☐ 180 Days Benefit Term: ☐ 10 Year ☐ 15 Year ☐ Unemployment Waiver of Premium	☐ Social Insurance Substitute Benefit Amount ☐ Supplemental Benefit Term Rider Benefit Amount Elimination Period: ☐ 90 Days ☐ 180 Days Benefit Term: ☐ 10 Year ☐ 15 Year ☐ Unemployment Waiver of Premium

SECTION 3: RETIREMENT PROTECTION PLUS – SEPARATE POLICY

A. Benefit Amount: $

B. Premium Structure: ☐ Level ☐ Graded

C. Elimination Period: ☐ 180 Days ☐ 360 Days

D. Supplemental Benefits:
You may only select one in each row.

1. Increase Option	☐ FIO: $
2. Cost of Living Adjustment (COLA)	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum

PRODUCER'S CERTIFICATION (COMPLETE IN ALL CASES)

This Producer's Certification is to be used with the application for insurance on:

First Name	Middle Initial	Last Name	Suffix
Wairimu		Waiyaki	

1. How well do you know the proposed insured?

[X] Known well for [20] years. [ ] Known slightly for [ ] years. [ ] Met very recently. [ ] Relative? [ ]

2. A. Do you have knowledge or reason to believe that this application involves a replacement as defined under applicable state law or Company procedure? ..... [ ] Yes [X] No

B. If "Yes," did you deliver appropriate Notice Regarding Replacement, where applicable? ..... [ ] Yes [X] No

3. If submitting under a discount program, please provide the following details:

Program type:

[ ] Student/Resident [ ] Association [ ] Qualified Sick Pay Program [ ] Voluntary Insurance Program

[ ] Professional Group [ ] Group Conversion [ ] Executive Bonus (Sec. 162)

Program status: [ ] New [ ] Existing

If existing, provide program name and code:

4. Commissions:

Producer's Name	Producer's Code	Last 4 Digits of Producer's SSN	Servicing Producer (Check Only One)	Percentage	DIS Code (list once)
BENEDICT KEINGATTI	000HL911		X	100 %	
				%	
				%	
				%	
				%	
				%	

Answer questions 5 through 7 for new policies and option exercises with additional benefits, enhancements to existing benefits, or shortening of the elimination period:

5. Did you deliver to the proposed insured the notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Disclosure, the MIB Pre-Notice, and Medical Records? ..... [X] Yes [ ] No

6. Have you suggested the possibility of an extra premium for any reason? ..... [ ] Yes [X] No

7. Have you suggested the possibility of an exclusion rider for any reason? ..... [ ] Yes [X] No

Remarks (and additional instructions):

I represent that, to the best of my knowledge and belief, the information provided in this report by the proposed insured and/or owner in the application is complete, accurate and correctly recorded, and there is nothing adversely affecting the insurability of the proposed insured other than as indicated in the application. I also represent that I gave all required forms on or before the date the application was taken. I represent that I am duly licensed in the state in which this application was signed.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at City, State

Little Elm TX

Today's Date (mm/dd/yyyy)

8/3/2021

Type or Print Producer's Name

BENEDICT KEINGATTI

Signature of Soliciting Producer

eSigned by BENEDICT KEINGATTI

State(s) Where Licensed